

Accepted By: \_\_\_\_\_ Staff Initials  
Received from: \_\_\_ Medical \_\_\_ Dental

Check if entered into Smart sheet: \_\_\_\_\_  
Method of Release Mail: \_\_\_\_\_ Pickup: \_\_\_\_\_ Fax: \_\_\_\_\_



**BLUESTEM HEALTH**  
1021 N 27<sup>th</sup> St Lincoln, NE 68503 | Phone: (402) 476-1455 | Fax: (402) 476-1655  
**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

**Please print request in black/blue ink, include either address or fax number.**

\_\_\_\_\_  
Patient Name Date of Birth

<b>Release Information From:</b>	<b>Release Information to:</b>
Name:	Bluestem Health Medical Records
Address:	1021 N. 27 <sup>th</sup> Street Lincoln, NE 68503
Phone:	Phone: 402-476-1455
Fax:	Fax: 402-476-1655

Purpose/Reason for Release: \_\_\_\_\_

**Release the following information:**

- Entire Medical Record     Lab Reports     Immunizations  
 Medication Record     Dental Records     Other(Specify Below)

I consent to the release of health records including HIV/AIDS status and alcohol/substance abuse treatment/testing  
Initials: \_\_\_\_\_ Date: \_\_\_\_\_

*By signing this form, I authorize the above facility/provider/person/entity to disclose medical information concerning the above named patient to the party identified in the section titled "Release Information to". I understand that I may revoke this authorization at any time in writing or it will automatically expire 12 months from the date signed below. My signature indicates that I am authorized to obtain or release records on the above named patient. I understand that once my records are released, there's no guarantee preventing re-disclosure.*

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent:** \_\_\_\_\_ **Relationship to patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_